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CAGE

The **CAGE** is a simple, four-question screening instrument that can be used in a variety of settings. The CAGE questions are:

- Have you ever felt you ought to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?

Two or more affirmative answers are considered indicative of probable alcoholism, while one affirmative answer indicates that the patient's alcohol use deserves further evaluation.

******The above is from "Principles of Addiction Medicine, Second Edition";
American Society of Addiction Medicine (ASAM).

CAGE is one of the Health Factors within RPMS PPC and BHS v3.0 applications. It is commonly used in IHS clinics (often prenatal clinic) as a quick and easy screening tool. It is not a mandatory field in BHS v3.0.

Many providers choose to use the **CAGE-T. T** stands for **T**olerance. How many beers or drinks does it take for you to get high, or to get a buzz? It is believed that CAGE-T may be a more sensitive tool than CAGE alone. In the Health Factor field instead of "Quantity" one can enter a response for "Tolerance" as long as it is known that the provider is substituting "Tolerance" for "Quality." This can be noted in the SOAP note.

A response could be: **CAGE 1/4 T-4**

This would indicate one positive response out of the four questions total with a Tolerance of 4 beers. The recommendation would be that the client be referred to an alcohol/substance abuse provider for a more comprehensive assessment.

Multiaxial Evaluation Form

The following form is offered as one possibility for reporting multiaxial evaluations. In some settings, this form may be used exactly as is; in other settings, the form may be adapted to satisfy special needs.

AXIS 1: Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Diagnostic Code	DSM-IV TR Name
__ __ __.__ __	_____
__ __ __.__ __	_____
__ __ __.__ __	_____

AXIS II: Personality Disorders
Mental Retardation

Diagnostic Code	DSM-IV TR Name
__ __ __.__ __	_____
__ __ __.__ __	_____

AXIS III: General Medication Conditions

ICD-9-CM Code	ICD-9-CM Name
__ __ __.__ __	_____
__ __ __.__ __	_____
__ __ __.__ __	_____

AXIS IV: Psychosocial and Environmental Problems

Check:

_____ Problems with primary support group *Specify:* _____
_____ Problems related to social environment *Specify:* _____
_____ Educational Problems *Specify:* _____
_____ Occupational Problems *Specify:* _____
_____ Housing Problems *Specify:* _____
_____ Economic Problems *Specify:* _____
_____ Problems with access to health care services *Specify:* _____
_____ Problems related to interaction with the legal system/crime *Specify:* _____
_____ Other psychosocial and environmental problems *Specify:* _____

AXIS V: Global Assessment of Functioning Scale

Score _____
Time frame: _____

from DSM-IV, American Psychiatric Association, Washington, 1994

Examples of How to Record

Results of a DSM-IV TR Multiaxial Evaluation

Example 1:

Axis I	296.23	Major Depressive Disorder, Single Episode, Severe without Psychotic Features
	305.00	Alcohol Abuse
Axis II	301.6	Dependent Personality Disorder
		Frequent use of denial
Axis III		None
Axis IV		Threat of job loss
Axis V		GAF = 35 (current)

Example 2:

Axis I	300.4	Dysthymic Disorder
	315.00	Reading Disorder
Axis II	v71.09	No Diagnosis
Axis III	382.9	Otitis Media, recurrent
Axis IV		Victim of Child Neglect
Axis V		GAF = 53 (current)

Example 3:

Axis I	293.83	Mood disorder due to Hypothyroidism, with Depressive Features
Axis II	v71.09	No Diagnosis
Axis III	244.9	Hypothyroidism
	365.23	Chronic angle-closure Glaucoma
Axis IV		None
Axis V		GAF = 45 (on admission)
		GAF = 65 (at discharge)

Example 4:

Axis I	v61.10	Partner Relational Problem
Axis II	v71.09	No Diagnosis
Axis III		None
Axis IV		Unemployment
Axis V		GAF = 83 (highest level past year)

from DSM-IV, American Psychiatric Association, Washington, 1994

Global Assessment of Functioning (GAF) Scale*

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate e.g. 45, 68, 72.)
91–100	Superior functioning in a wide range of activities. Life' problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms
81-90	Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members)
71-80	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g. temporarily falling behind in school work)
61-70	Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms (e.g. flat effect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).
41-50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).
31-40	Some impairment in reality testing or communication (e.g. speech is at all times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgement, thinking or mood (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school.
21-30	Behaviour is considerable influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home, or friends).
11-20	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears faeces) OR gross impairment in communication (e.g. largely incoherent or mute).
1-10	Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

* Table from DSM-IV, American Psychiatric Association, Washington, 1994.

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CDMIS Staging Tool

When a client comes to an A/SA program for help, the first thing to do is to screen and evaluate that client to identify his problems, the severity, and how they have affected his life. Once this is done, the most appropriate treatment for them is decided upon and recommendations are discussed with the client and/or family and/or pertinent clients or agencies (e.g., courts, judges, physicians, employers, etc.). There must be an objective way to measure the progress of the client while in treatment. The CDMIS staging tool helps identify where the client is in terms of how severe his symptoms are and helps the counselor decide what type of treatment is most appropriate. The client may not always agree, and the recommended treatment might not always be available, but the severity has been documented. The client's needs are important. Documenting these unmet needs helps justify requests for additional resources and programs. Likewise, using this tool also provides an objective guide that gives counselors and others more confidence in recommendations. The counselor uses this tool to compare how the client is progressing at different points of time in his treatment.

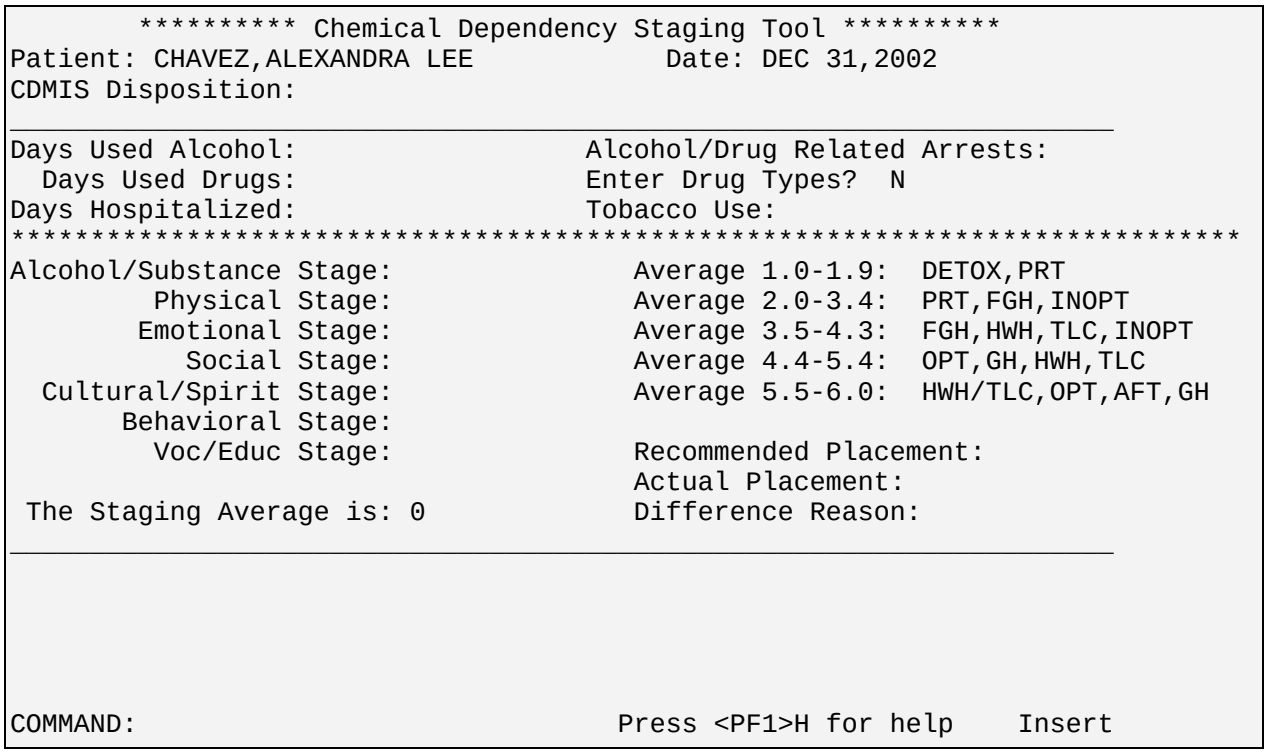


Figure 0-1: CDMIS Staging Tool

When to Use This Tool

- When a counselor sees a client for the first time
- When a client is transferred to another component, is discharged, or is closed
- When a client was previously discharged or closed
- When a counselor finds it useful (e.g., follow-up, in counseling where the counselor is reviewing progress or lack of it with the client, to help with a court report, other special requests, etc.)

How to Use This Tool

1. Get a complete psychosocial and drinking history (or update it if this is not the initial contact) from the client. Be sure to include all six factors listed in the factor column.
2. Look at the stages listed next to the first factor, alcohol, substance dependence.
3. Find the stage that best describes the client based on what has been obtained from the psychosocial, medical, and drinking histories and other reliable sources. What has been learned from the client will probably not match the phrases exactly, so choose the one that best describes or fits the client right now.
4. Circle that paragraph or phase.
5. Repeat steps 2, 3, and 4 for each of the remaining seven factors (physical, emotional, social, cultural/spiritual, behavioral and vocational/education problems).
6. Look at the top of the column the counselor circled to see a stage number. Put that stage number in the proper box on the CDMIS-1 worksheet or enter it into CDMIS on the computer.
7. Look at the staging tool and see where most of the circles fall. Look at the bottom of the staging tool and the counselor will see the following recommended placements: detox, MED (Medical), MHC (Mental Health Component/Setting); PRT (Primary Residential Treatment); TLC/HWH (Transitional Living Center/Halfway House); TFH (Therapeutic Foster Home); OPT (Outpatient Treatment) and AFT (Aftercare). (Drop-In Centers and EAPs are not listed but are considered to be OPT/AFT.) Choose the one that corresponds to where most of the circles fall. This will be the recommended treatment unless the client has a problem that is worse (lower number), that needs immediate attention (e.g., five of the six factors are stage 3, but physical is stage 1 due to a critical medical problem). If there is a critical problem (as in the example), use that number as the recommended treatment. Always use good judgment—the staging tool is a guide, not a commandment.
8. Place the client in the recommended treatment if possible. If not, place him in the treatment that comes closest that the client can and will enter. (The closest would be the one nearest the recommended placement on the bottom of the staging tool.)
9. Put the actual placement in the correct boxes on the worksheet or enter it into the computer. If there is a difference between the recommended and actual placement, include the reason in the boxes or in the computer.
10. Write what the counselor did and why in the client's record.
11. File the tool in the client's record and redo and/or review it as desired.

Factor	STAGE 1	STAGE 2	STAGE 3	STAGE 4	STAGE 5	STAGE 6
Alcohol/ Substance Abuse History (*)	Withdrawal symptoms	Reported compulsive drinking or drug use	Preoccupation or daily drinking or frequent binges and denial	Some alcohol or drug-related problem building up to abuse	Plans to maintain sobriety, still needs support	Commitment to long-term sobriety, sober for 30 days or more, still needs support Factor score ( )
Physical (*)	Acute or threatening Medical conditions, such as liver, heart, or other body system	Needs additional care with health problems	Getting medical attention or medical problem under control or no known medical problems	Sleeps well, controls diet, needs plan for physical activity.	Maintains good health practices, including regular exercise. Still needs support.	Sees results of good health, practices for 30 days or more Factor score ( )
Emotional	Feels worthless, situation is hopeless, possible suicide, w/ alcohol/ substance abuse	Negative attitude/ depression, anxiety or anger w/ alcohol/ substance abuse	Accepts responsibility for emotions and sees need to explore alternatives	Deals with most situations successfully with support.	Self-confident, deals with emotions successfully for 30 or more days.	Positive self-image, effective problems-solving for 30 or more days. Factor score ( )
Social/Family	No social support & no friends, little or no contact with family.	Associates w/others to include family only to use or talk about alcohol & drugs.	Aware of conflicts and/or need to change lifestyle. Family might become involved in recovery.	Belongs to network of non-drinking & non-using friends, has extensive support from family.	Friends & activities, improving the quality of life, still needs support from others, as well as family.	Healthy network of family/friends w/man activities for 30 days or more. Factor score ( )
Cultural/ Spiritual	Denial that beliefs can have a positive influence on life.	Confusion or conflicts about belief system.	Able to discuss beliefs systems, aware that beliefs can have a positive influence on life.	Aware that beliefs can have a positive influence on life.	Beliefs contributing to all life areas.	Practicing beliefs consistently for 30 days or more. Factor score ( )
Behavioral	Acute or life-threatening behavioral problems.	Major behavioral problem w/home, school, work, or community.	Starting to accept responsibility for negative social behavior.	Practices reducing negative behavioral situations.	Maintaining positive behavioral control with support.	Positive self-image, .acceptable social behavior for 30 days or more. Factor score ( )
Vocational/ Educational	Not working/not caring for family.	Some work activity, but not taking much responsibility in family/home	Plans to attend school/training or working regularly or full-time.	Basic work/home care related activity, having taken on added responsibility.	Fully engaged in work, home care, subsistence, or School/training.	Successful in work, home care, subsistence and/or school and felling good for 30 days or more. Factor score ( ) Sum of scores ( ) Divide by for scale score ( )

Stages > > > > > > > 1 5 2 5 3 5 4 5 5 5 6

PLACEMENTS: < DETOX > < HALFWAY HOUSE/TLC >

< PRIMARY RESIDENTIAL TREATMENT >

< FAMILY GROUP HOME >< OUTPATIENT TREATMENT >

< GROUP HOME >

< INTENSIVE OUTPATIENT >< AFTERCARE >

(*) If a client places at Stage 1 on either factor… Alcohol/substance History or Physical, it is recommended that DETOX (hospital admission) be considered the starting placement.

STAGING TOOL (PART 2)

NUMERICAL AVERAGE AND PLACEMENT ABBREVIATION	1.0 ----- 1.9	2.0 ----- 3.4	3.5 ----- 4.3	4.4 ----- 5.4	5.5 ----- 6.0
	DETOX PRT	PRT FGH INOPT	FGH HWH TLC INOPT	OPT GH HWH TLC	HWH /TLC OPT AFT GH

ABBREVIATIONS DEFINED

DETOX	Medical detoxification, requiring hospitalization. The length of time is normally 3-5 days, depending on medical need.
PRT	Primary Residential Treatment, may be 21 or more days and might include social detoxification at initial admission.
FGH	Family Group Home, a supportive living environment with treatment and other related services.
INOPT	Intensive Outpatient, generally is attended for 5-8 hour per day during the week, and has much of the same treatment content as a PRT without housing the client overnight. The length varies.
HWH	Halfway House, a residential setting which provides an alcohol/drug-free living environment. Aftercare and other services are provided by community-based agencies and organizations, though 12-Step Meetings may be held there. The length varies.
TLC	Therapeutic Living Center, very similar to a HWH but can also provide some basic recovery/treatment services. The length varies.
OPT	Outpatient treatment, can include any number of community based treatment/recovery services. The length varies.
GH	Group Home, normally for persons under the age of 18, and provides an alcohol/drug free living environment. The length varies.
AFT	Aftercare, long term support activities for recovery such as 12-Step meetings and follow-up activities. Length varies but is usually seen as lasting two or more years.

VISIT TYPES AND FUNCTIONS (TABS)

FUNCTIONS (TABS)	VISIT TYPES							
	No show	**Info/Contact**	**Brief**	**Intake**	**Regular**	**A/SA**	**SAN (New)**	**SAN (F/U)**
POV	X	X	X	X	X	X	X	X
CC/SOAP	X	X	X	X	X	X	X	X
Rx Notes			X	X	X	X	X	X
Visit Admin	X	X	X	X	X	X	X	X
Wellness				X	X	X		
CD Staging Tool				X	X	X		
Intake				X				
CD Data						X		
SAN (New)							X	
SAN (F/U)								X

Each Visit Type includes three basic tabs or functions:

- POV
- CC/SOAP
- Visit Admin

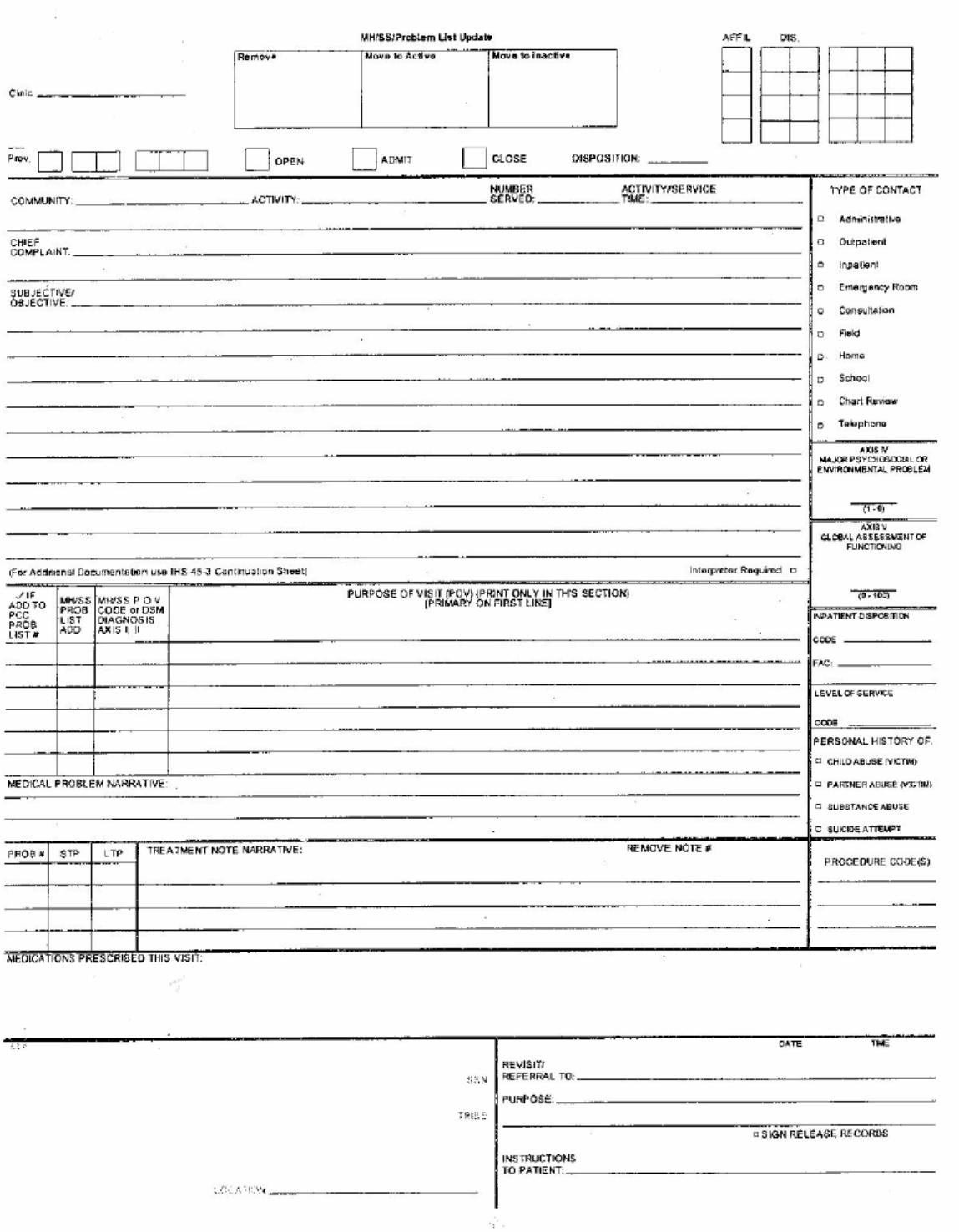
The POV and Visit Admin tabs contain required elements that must be completed before an encounter record can be saved. The CC/SOAP tab is optional.

Mental Health or Social Services programs that choose to use the CD Staging Tool should use either the Intake or Regular visit type to record their encounters.

Substance Abuse programs who need to record Component Code, Type of Component, Type of Contact, Days in Residential Treatment and Days in Aftercare should use the A/SA visit type.

Sample Encounter Forms

Individual



MH/SS/Problem List Update

Remove	Move to Active	Move to Inactive

AFF/L DIS.

Clinic _____

Prov. ☐ ☐☐ ☐☐☐ ☐ OPEN ☐ ADMIT ☐ CLOSE DISPOSITION: _____

COMMUNITY: _____ ACTIVITY: _____ NUMBER SERVED: _____ ACTIVITY/SERVICE TIME: _____

CHIEF COMPLAINT: _____

SUBJECTIVE/ OBJECTIVE: _____

(For Additional Documentation use IHS 45-3 Continuation Sheet) Interpreter Required ☐

✓ IF ADD TO PCC PROB LIST #	MH/SS PROB LIST ADD	MH/SS P.O.V. CODE or DSM DIAGNOSIS AXIS I, II	PURPOSE OF VISIT (POV) (PRINT ONLY IN THIS SECTION) [PRIMARY ON FIRST LINE]

MEDICAL PROBLEM NARRATIVE: _____

PROB #	STP	LTP	TREATMENT NOTE NARRATIVE: REMOVE NOTE #

MEDICATIONS PRESCRIBED THIS VISIT: _____

TYPE OF CONTACT
- ☐ Administrative
- ☐ Outpatient
- ☐ Inpatient
- ☐ Emergency Room
- ☐ Consultation
- ☐ Field
- ☐ Home
- ☐ School
- ☐ Chart Review
- ☐ Telephone

AXIS IV MAJOR PSYCHOSOCIAL OR ENVIRONMENTAL PROBLEM _____ (1 - 9)

AXIS V GLOBAL ASSESSMENT OF FUNCTIONING _____ (0 - 100)

INPATIENT DISPOSITION
CODE _____
FAC: _____

LEVEL OF SERVICE
CODE _____

PERSONAL HISTORY OF:
- ☐ CHILD ABUSE (VICTIM)
- ☐ PARTNER ABUSE (VICTIM)
- ☐ SUBSTANCE ABUSE
- ☐ SUICIDE ATTEMPT

PROCEDURE CODE(S) _____

SSN

TRIBE

LOCATION _____

DATE TIME

REVISIT/ REFERRAL TO: _____

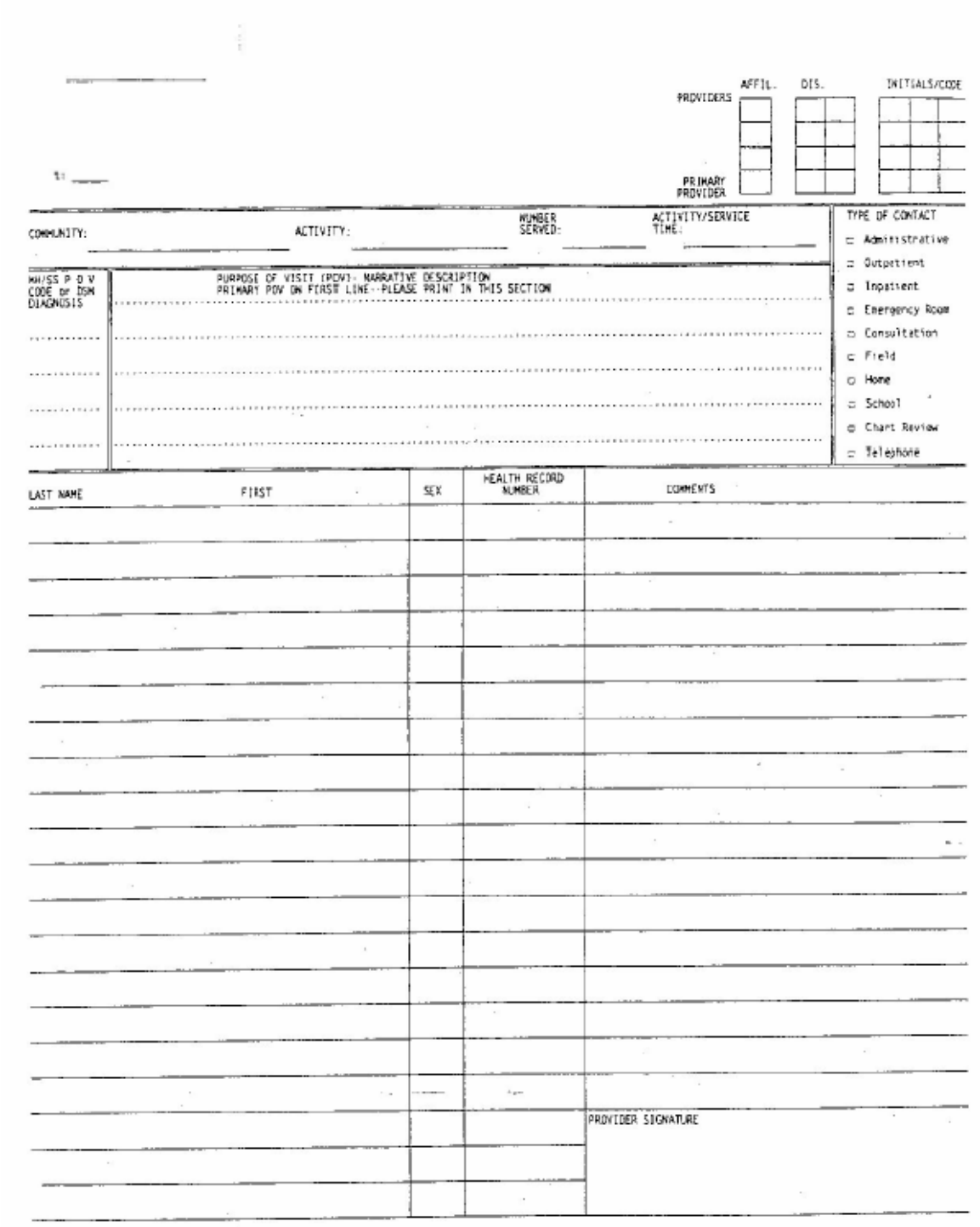
PURPOSE: _____

☐ SIGN RELEASE RECORDS

INSTRUCTIONS TO PATIENT: _____

Sample Encounter Forms

Group



PROVIDERS | AFFIL. | DIS. | INITIALS/CODE
PRIMARY PROVIDER

COMMUNITY: | ACTIVITY: | NUMBER SERVED: | ACTIVITY/SERVICE TIME:

TYPE OF CONTACT
- Administrative
- Outpatient
- Inpatient
- Emergency Room
- Consultation
- Field
- Home
- School
- Chart Review
- Telephone

MH/SS P.O.V. CODE or DSM DIAGNOSIS

PURPOSE OF VISIT (POV) - NARRATIVE DESCRIPTION
PRIMARY POV ON FIRST LINE - PLEASE PRINT IN THIS SECTION

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	COMMENTS
				PROVIDER SIGNATURE

Suicide Surveillance in RPMS

Suicide, especially among youth and young adults, is a serious public health concern in American Indian/Alaska Native (AI/AN) communities. The CDC reports that 2004 suicide rates were highest among whites and second highest among AI/AN men, and Native Americans have the highest rate of suicide in the 15-24 age group. Surveillance, data collection and data analysis are integral components to a comprehensive community or public health agency response to suicide.

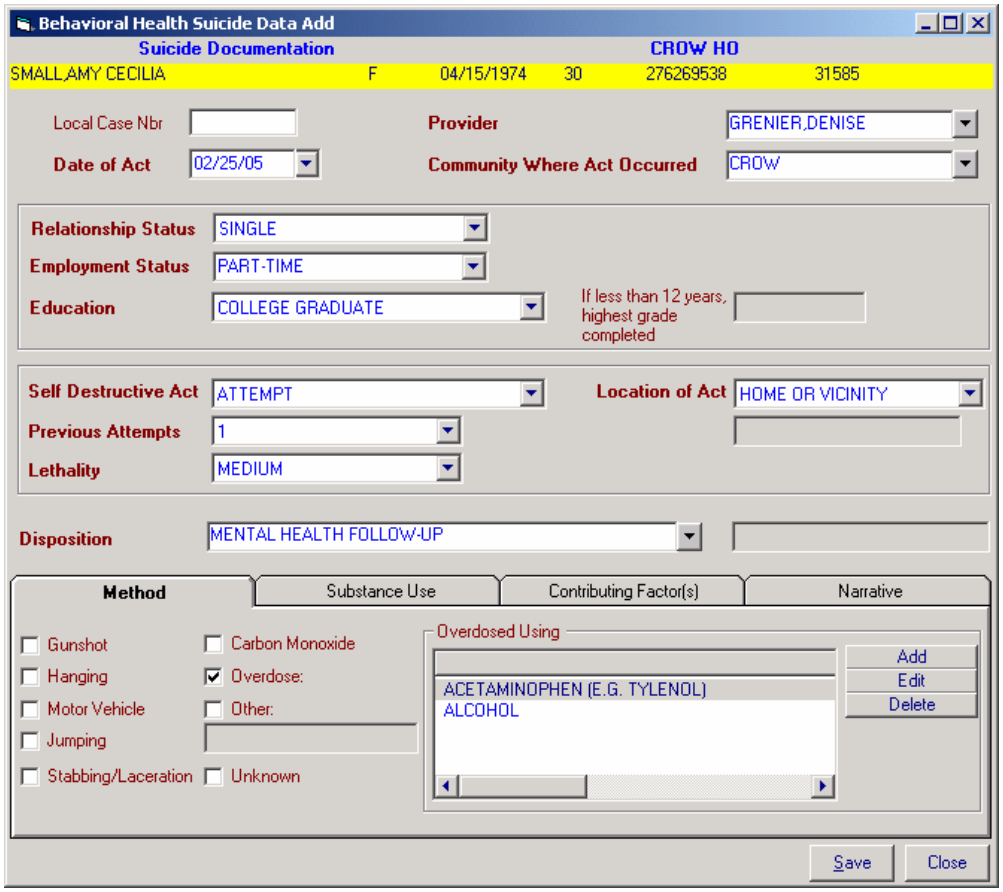
In support of Agency healthcare IT initiatives and GPRA clinical performance measures, the suicide surveillance tool currently found in the RPMS behavioral health applications (BHS v3.0 and BH GUI) will soon be available RPMS-wide in PCC, PCC+ and the IHS Electronic Health Record. The suicide surveillance tool allows clinicians to document incidents of suicide, including ideations with intent and plan, attempts and completions. It captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors and other useful epidemiological information. With the expansion of suicide data collection to the primary and emergency care settings, IHS will have more comprehensive and reliable information about these occurrences. The data will be used to better understand the prevalence of suicide in the populations served by I/T/U healthcare facilities and to inform intervention and prevention activities.

GPRA Suicide Clinical Indicator

The purpose of the GPRA suicide clinical indicator is to support suicide prevention by collecting comprehensive data on the incidence of suicidal behavior.

2005 Performance Indicator – Integrate the RPMS Behavioral Health suicide surveillance tool into RPMS

2006 Performance Indicator – Establish baseline data on suicide using the RPMS suicide surveillance tool



Most patients with serious suicidal ideation or attempts present first to providers in primary or emergency care. The availability of the RPMS suicide surveillance tool for all providers in I/T/U healthcare settings will promote standardized and systematic documentation of suicide-related symptoms and events. Suicide data can be analyzed locally through RPMS reports and is exported nationally, so that we can develop a better understanding of this important public health problem.

Screenshot:
Suicide Surveillance Tool in Patient Chart v1.5 (BH GUI)

IHS Resource and Patient Management System
Behavioral Health Clinical Applications

What is BH GUI?

The IHS Office of Information Technology (OIT) released a graphical user interface version of the widely deployed Behavioral Health System (BHS v3.0) in January 2004. The BH GUI resides within IHS Patient Chart. It offers an alternative to the command-based "roll and scroll" interface typical of most RPMS applications by providing a user-friendly, Windows-like presentation where data is entered by a combination of mouse click and keyboard entry. The BH GUI focuses on the Data Entry module of BHS v3.0 with the goal of facilitating direct provider entry of clinical data. The Reports and Manager Utilities modules are still accessed via BHS v3.0.

BH GUI v1.5

An enhanced version of the Behavioral Health Graphical User Interface (BH GUI) will be released spring 2005. Modifications and enhancements as requested by users in the field include:

- Improved group functionality
- Updated DSM-IV-TR and ICD-9 codes
- Wellness Tab
- IPV/DV Screening Exam Code
- Modified Suicide Surveillance tool
- Additional security features

BH GUI v1.5 screenshots

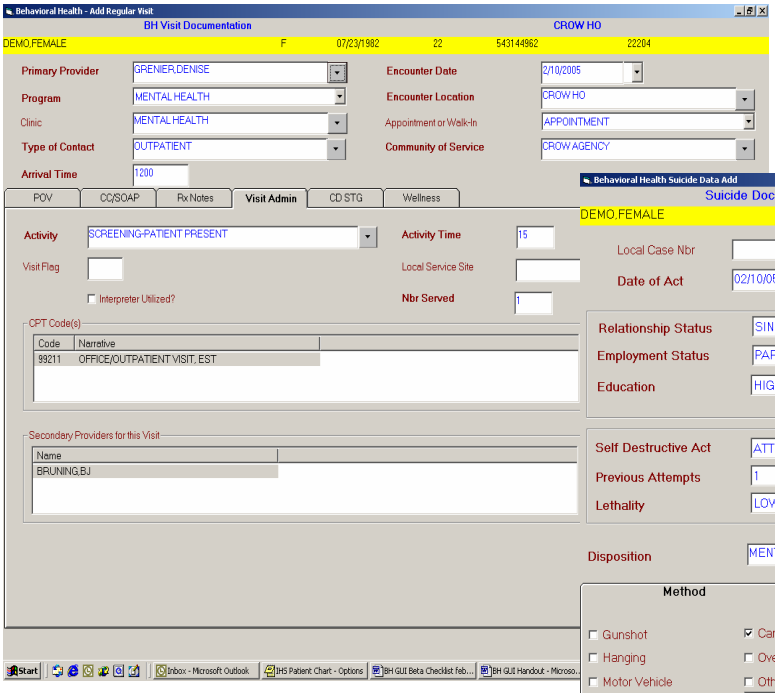


Figure 1. Visit Entry Screen

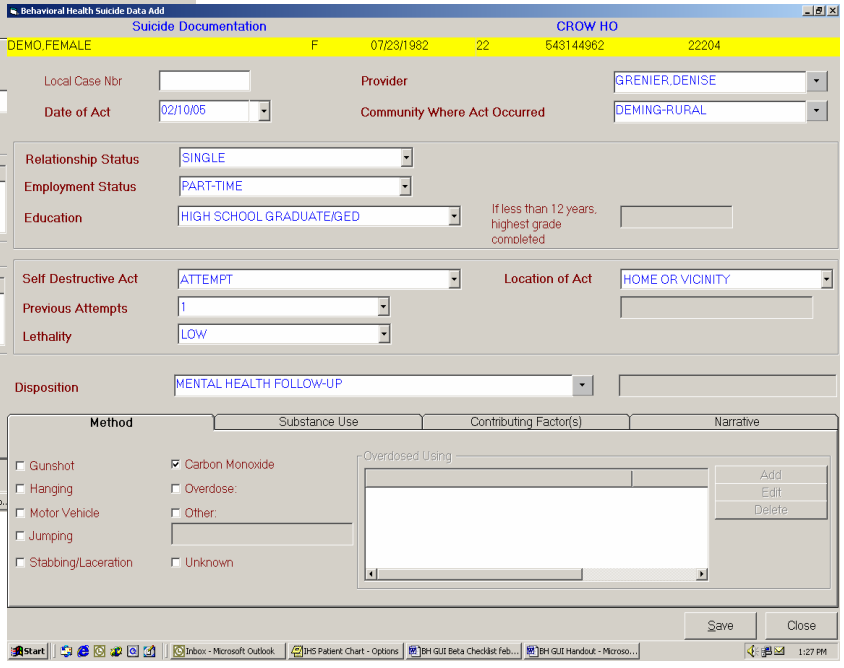


Figure 2. Suicide Screen

Why use BH GUI?

The behavioral health applications were designed to meet the unique documentation and reporting needs of I/T/U behavioral health providers from all disciplines, allowing users to record and report on both clinical and program activities. The BH applications interface with other RPMS applications, support third party billing, and assist sites in meeting JCAHO, CARF, and GPRA standards and reporting requirements. Graphical user interfaces are generally more intuitive and acceptable to those users familiar with Windows and Mac applications, and Patient Chart provides a readily accessible and user-friendly alternative to the existing RPMS behavioral health application. Many facilities currently using RPMS will already have the software and desktop requirements necessary to run Patient Chart. The BH GUI was developed with input from I/T/U BH providers in the field. A user-centric approach was critical in developing an application that facilitates direct provider entry of clinical information with the goal of improving quality of care, practice and program management, data collection, and data reporting to the IHS Division of Behavioral Health.

BH GUI v1.5 Functions			
Wellness Tab	BH and PCC Wellness activities	**CD Staging Tool**	Chemical Dependency Placement Tool
Patient Education	Topic, duration, level of understanding…	**Suicide Surveillance**	Ideation, Attempts, Completions, Epi data
IPV/DV Screening	Intimate Partner Violence/Domestic Violence	**Case Status**	Open, admit, close
Health Factor	Factor, severity, quantity…	**Rx Notes**	PCC and BH medication history
Treatment Plan	Establish, review progress, resolve	**BH Health Summary**	Generate BH Health Summary
Visits	Record individual patient encounters: Axis I - V, notes, billing info…	**Patient Information**	Designated Providers, personal history…
Groups	Record group encounters, replicate patient lists, view past groups	**Administrative Encounters**	Record administrative and program activities

Behavioral Health and the Electronic Health Record

A long-term application, Integrated Behavioral Health (IBH), is in development and will reside within the IHS Electronic Health Record (EHR). The EHR offers increased functionality including order entry of medications, labs and radiology, enhanced note-taking capability, consults and clinical reminders. Development plans for IBH also include importing the Veterans Administration's Mental Health Assistant (MHA) application. MHA allows providers to record, store and graph results of standardized psychological tests as well as other instruments. In addition IBH will include a robust treatment plan module incorporating clinical practice guidelines and treatment outcome measures. Access to BH clinical data will be restricted in accordance with federal laws and standards of care. IBH v1.0 will be released at the end of FY 2005.

For additional information:
visit http://www.ihs.gov/Cio/BH/index.asp
or contact Denise Grenier Denise.Grenier@na.ihs.gov; (520) 670-4865